emailed validation letter 11/30/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 11-16-11
Amount $1815.00 Ck#05409

I. IDENTIFICATION

Name LP Prestonsburg Riverview, LLC d/b/a Riverview Health Care Center

Address 79 Sparrow Lane

City/County/Zip Prestonsburg/Floyd/41653

Telephone number 606-886-9178 Email: admin.rivervw@shccs.com

Administrator Melissa Allen

Date facility operation began at current address 12/1978

Date facility began operation under current owner 6/1/08

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	121	121
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State
County
City
Private

Profit
Nonprofit

Individual
Partnership
Corporation
LLC

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.
N/A

(OVER)

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OFFICE OF INSPECTOR GENERAL

11/30

If facility owned or leased by a corporation, complete the following:

Name of corporation LP Prestonsburg Riverview, LLC

Address of corporation 12201 Bluegrass Parkway, Louisville, KY 40299

President or Chairman N/A

Vice President N/A

Secretary/CEO N/A

Treasurer N/A

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility. N/A

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. N/A

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner. N/A

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
LP O Holdings, LLC	**Signature Consulting Services, LLC** **Signature Clinical Consulting Services, LLC**
12201 Bluegrass Parkway	12201 Bluegrass Parkway
Louisville, KY 40299	Louisville, KY 40299

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative	Title	Date
	CFO	11-8-11

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)